DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 5/22/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	04/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey conducted April 5 through April 7, 2010, at Manchester Health Care Center, complaints TN00018262, TN00019013, TN00020346, TN00020718, TN00022072, TN00024228, and TN00025081 were investigated and no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	"This Plan of Correction affirms our allegation that Manchester Health Care Center is in substantial compliance with regulations and standards. This Plan of Correction has been respectfully developed as required for compliance with federal and state regulations. The Plan of Correction does not constitute an admission of any deficient practice, admission or agreement of the provider to the truth of the facts alleged, or conclusions set forth in the statement of deficiencies."	
F 254 SS=C	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide clean wash cloths for all residents. The findings included: Interview during the resident council meeting in the activity room on April 5, 2010, at 1:45 p.m., revealed a shortage of wash cloths. Interview on April 6, 2010, at 2:35 p.m., on 100 hall, with certified nurse assistant #2 and #5 revealed a frequent shortage of wash cloths. Observation on April 6, 2010, at 2:30 p.m. and 3:50 p.m.; April 7, 2010, at 7:45 a.m. and 9:15 a.m., revealed the following: No wash cloths in the "clean linen room", and fewer than 6 wash cloths on the 500 and the 100 hall linen carts. Interview with the administrator on April 7, 2010,	F 254	F254 Corrective action: One hundred dozen wash cloths ordered on 4/5/2010. They have been received and are in use. This action was completed by the Director of Environmental Services. All residents have the potential to be affected by this practice. Laundry staff was in-serviced on 4/13/2010 By Director of Environmental Services regarding adequate level of linen for care to be provided to the residents. The Quality Assurance Team will be in-serviced 4/14/2010 by Administrator to monitor for comments or issues regarding inadequate linen supply Regarding measures put into place to ensure others will not be affected by the practice; weekly rounds will be completed by the Environmental Services Director for adequate level of linen. An in-service will be provided to facility staff on 4/15/2010 to discuss informing EVS if linen supply is inadequate. As for monitoring to ensure identified practice does not recur, walking rounds will be completed by the Administrator Monday – Friday to monitor for adequate linen supply. The audits performed by the EVS Director will be reported to the Administrator weekly. Results of the monitoring will be reported to the QA Committee for analysis of findings. The Quality Assurance committee consists of the following" Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Rachel Anderson Administrator 4/19/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 254	Continued From page 1 at 11:30 a.m., in the conference room confirmed the frequent shortage of wash cloths.	F 254		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one (#14) of twenty-two residents reviewed. The findings included: Resident #14 was admitted to the facility on March 13, 2008, with diagnoses including Alzheimer's Dementia and Cerebral Vascular Accident (stroke). Medical record review of the Minimum Data Set dated February 11, 2010, revealed the resident had impaired short and long term memory, and required assistance with all activities of daily living. Medical record review of the April 2010, physician's orders revealed " ...Apply geri sleeves (skin protectors) to both arms at all times AM PM Noc (night)..." Observation on April 7, 2010, at 7:10 a.m., and 7:40 a.m., in the resident's room, revealed the resident in the bed without the geri sleeves on, and multiple small bruises on the arms.	F 281	F281 Corrective action for resident affected included application of appropriate assistive device per the physician's orders and immediate individual counseling and education with the staff providing care for the resident on 4/7/2010 by the QA nurse and Staff Education nurse. Random audits have been performed since 4/7/2010. An in-service by RN Nurse Educator on April 15, 2010 included following physicians orders to ensure that each resident receives assistive devices to prevent accidents. As for monitoring to ensure that the identified practice does not recur, random audits will continue to be performed weekly x 4, monthly x3, and then bi-annually by the RN QA coordinator and DON to determine if the physicians orders are being followed and that the residents are receiving assistive devices to prevent accidents. Results of this monitoring will be reported to the QA committee for analysis of findings. Changes will be made to the action plan based on analysis. The QA committee consists of the following: Medical director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010

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F 281	Continued From page 2 Observation on April 7, 2010, at 8:15 a.m., in the resident's room revealed Certified Nurse Assistant #2 and #3 dressed the resident and transferred the resident to the geri chair, failed to apply the geri sleeves, and left the resident's room. Observation on April 7, 2010, at 9:45 a.m., in the resident's room revealed the resident in the geri chair without the geri sleeves applied. Observation on April 7, 2010, at 10:40 a.m., in the activity room with the Registered Nurse Staff Education Coordinator revealed the resident sitting in the geri chair without the geri sleeves applied. Review of the April 2010, physician's orders on April 7, 2010, at 10:42 a.m., at the nurse's desk with the Registered Nurse Staff Education Coordinator and the Registered Nurse Quality Assurance Coordinator confirmed the physician's orders " ... Apply geri sleeves (skin protectors) to both arms at all times AM PM Noc (night) ..." Interview with the Registered Nurse Staff Education Coordinator at that time confirmed the resident did not have the geri sleeves applied as ordered by the physician.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to safely transfer two (#1, #2) of twenty-two residents reviewed. The findings included: Resident #1 was admitted to the facility on October 30, 2009, with diagnoses including Pubis Fracture from a fall and Senile Dementia. Medical record review of the Minimum Data Set (MDS) dated January 20, 2010, revealed the resident had impaired short term memory, impaired decision making skills, required assistance with transfers, was non-ambulatory, and had fallen in the past 31-180 days. Observation on April 6, 2010, at 7:05 a.m. revealed Certified Nurse Assistant (CNA) #1 assisted resident #1 to sit on the side of the bed without first placing a gait belt on the resident to assist with the transfer. CNA #1 told the resident to put the arms around CNA #1's waist but the resident was not able to comply. Observation revealed the CNA #1 pulled the resident off the side of the bed and the resident was unable to stand well and started to slide down. The CNA was able to get the resident to the front of the wheel chair preventing the resident from falling to the floor. Interview with CNA #1 on April 6, 2010 at 7:08 a.m. in the resident's room confirmed the CNA should have used a transfer belt. Resident #2 was admitted to the facility on	F 323	F323: Corrective action included immediate individual counseling and education with CNA #1 and #2 in regards to proper transfer of the resident and appropriate use of the lift by the QA nurse and Staff Education nurse on 4/7/2010. The lift and sling was immediately labeled do not use and then removed from the hall. The sling was repaired by the end of the day and is now in working order. Facility lifts and the sling buckles were checked 4/7/2010 and found to be in working order at this time. As all residents had the potential to be affected by this practice, the facility performed a house wide audit on 4/7/2010 to ensure appropriate resident transfers. All lifts and slings were checked and found to be in proper working order. An in-service for nursing staff was completed April 15, 2010 by RN Nurse Educator and included following resident plan of care regarding transfers and appropriate use of lifts. This is to ensure that each resident receives adequate supervision and assistance to prevent accidents and injury. Monitoring will include random audits to be continued weekly x4, monthly x2, and then quarterly by the RN QA Coordinator and DON to determine if the residents are being transferred appropriately and that lifts are in working order and are used correctly. This will ensure that the identified practice does not recur and that our residents remain safe from injury. Results of this monitoring will be reported to the QA committee for analysis of findings Changes will be made to the action plan based on analysis. The QA committee consists of the following: Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010

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F 323	Continued From page 4 November 6, 2008, with diagnoses including Alzheimer's Dementia, Diabetes, and a History of Colon Cancer. Medical record review of the MDS dated February 5, 2010, revealed the resident had impaired short and long term memory, impaired decision making skills, and required assistance with all activities of daily living including transfers. Observation on April 7, 2010, at 7:30 a.m., in resident #2's room revealed CNA #2 assisted resident #2 to the side of the bed and applied the sling around the resident's back without fastening the safety belt. The CNA instructed resident #2 to hold onto the grips on the lift. The resident required instruction several times due to confusion. CNA #2 used the lift to raise the resident off the bed and while the resident was dangling approximately three feet from the floor, the CNA retrieved the resident's wheel chair from the bathroom and lowered the resident into the wheel chair. Interview with CNA #2 on April 7, 2010, at 7:40 a.m., in the resident's room revealed part of the buckle for the safety belt was missing and the CNA was unable to fasten it for the resident's safety. Observation on April 7, 2010, at 7:55 a.m., in resident #22's room, with the Registered Nurse Staff Education Coordinator revealed CNA #2 preparing resident #22 to be transferred in the lift with the safety belt buckle missing. Continued observation revealed the Registered Nurse Staff Education Coordinator checked the safety belt and part of the safety belt buckle was missing. Interview on April 7, 2010, at 7:56 a.m., with the	F 323		

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F 323	Continued From page 5 Registered Nurse Staff Education Coordinator confirmed the buckle was missing and the lift was not safe to use for transferring residents. The RN Staff Education Coordinator secured another lift to facilitate the transfer.	F 323		